Abnormal psychology

- Abnormal psychology is concerned with understanding the nature, causes, and treatment of mental disorders.

What Do We Mean by Abnormality?

- Suffering: If people suffer or experience psychological pain we are inclined to consider this as indicative of abnormality.
- Maladaptiveness: Maladaptive behavior is often an indicator of abnormality.
- Statistical Deviancy: The word abnormal literally means “away from the normal.”
- Violation of the Standards of Society:
- Social Discomfort:
- Dangerousness:

- Within DSM-5, a mental disorder is defined as a syndrome that is present in an individual and that involves clinically significant disturbance in behavior, emotion regulation, or cognitive functioning.
- Diagnostic and Statistical Manual of Mental Disorders. This manual, commonly referred to as the DSM, is revised and updated from time to time. The current version, called DSM-5, was published in 2013.

Terms

- Epidemiology is the study of the distribution of diseases, disorders, or health-related behaviors in a given population.
- The term prevalence refers to the number of active cases in a population during any given period of time.
- Incidence: This refers to the number of new cases that occur over a given period of time (typically 1 year).
- Comorbidity is the term used to describe the presence of two or more disorders in the same person. Comorbidity is especially high in people who have severe forms of mental disorders

- Mass Madness, also known as mass psychogenic illness or mass hysteria, refers to:
- A phenomenon in which a large group of people develop similar irrational behaviors, beliefs, or symptoms of illness without a clear medical or physical cause, often triggered by fear, stress, or cultural beliefs.

- Tarantism was a form of mass hysteria or mass psychogenic disorder that occurred in Southern Italy during the Middle Ages, particularly between the 14th and 17th centuries.
- People believed that they had been bitten by a tarantula spider, and the only cure was to dance frenetically to rid themselves of the poison.
- **Lycanthropy** is a **rare psychological disorder (delusion)** in which a person **believes they have transformed into a wolf or another animal**.

- **Deinstitutionalization** refers to the **process of reducing or eliminating long-term psychiatric hospital stays**, and **shifting the treatment of individuals with mental illness to community-based settings**.
- resilience—the ability to adapt successfully to even very difficult circumstances.

- **Genotype**:
  → The **genetic makeup** of an individual – the actual set of **genes inherited** from one's parents.
  → Example: A person may have a gene for **brown eyes** or **risk for depression**.

- **Phenotype**:
  → The **observable traits or characteristics** of an individual – the way **genes are expressed**, influenced by both **genetics and environment**.
  → Example: Eye color, height, behavior, or presence of a mental disorder.

ego psychology

- According to this view, psychopathology develops when the ego does not function adequately to control or delay impulse gratification or does not make adequate use of defense mechanisms when faced with internal conflicts. This school became known as ego psychology.
- One new direction was that taken by his daughter Anna Freud (1895–1982),

Authoritative

Parents are high on warmth and moderate on control, very careful to set clear limits and restrictions regarding certain kinds of behaviors.

Research Shows:
Children tend to be friendly and to show development of general competencies for dealing with others and with their environments.

Authoritarian

Parents are low on warmth and high on control and often cold and demanding.

Research Shows:
Children tend to be conflicted, irritable, and moody. When followed into adolescence, these children have more negative outcomes, the boys doing particularly poorly in social and cognitive skills.

Permissive/ Indulgent

Parents are high on warmth and low on control and discipline.

Research Shows:
Children tend to be impulsive and aggressive. Overly indulged children are characteristically spoiled, selfish, impatient, inconsiderate, and demanding.

Neglectful/ Uninvolved

Parents are low on warmth and low on control.

Research Shows:
Children tend to be moody and to have low self-esteem and conduct problems later in childhood. They also have problems with peer relations and with academic performance.

- **Dysrhythmia** (also called **arrhythmia**) refers to an **abnormal rhythm of the heart**, where the heartbeat is **too fast, too slow, or irregular**.

Chapter 2 Stress

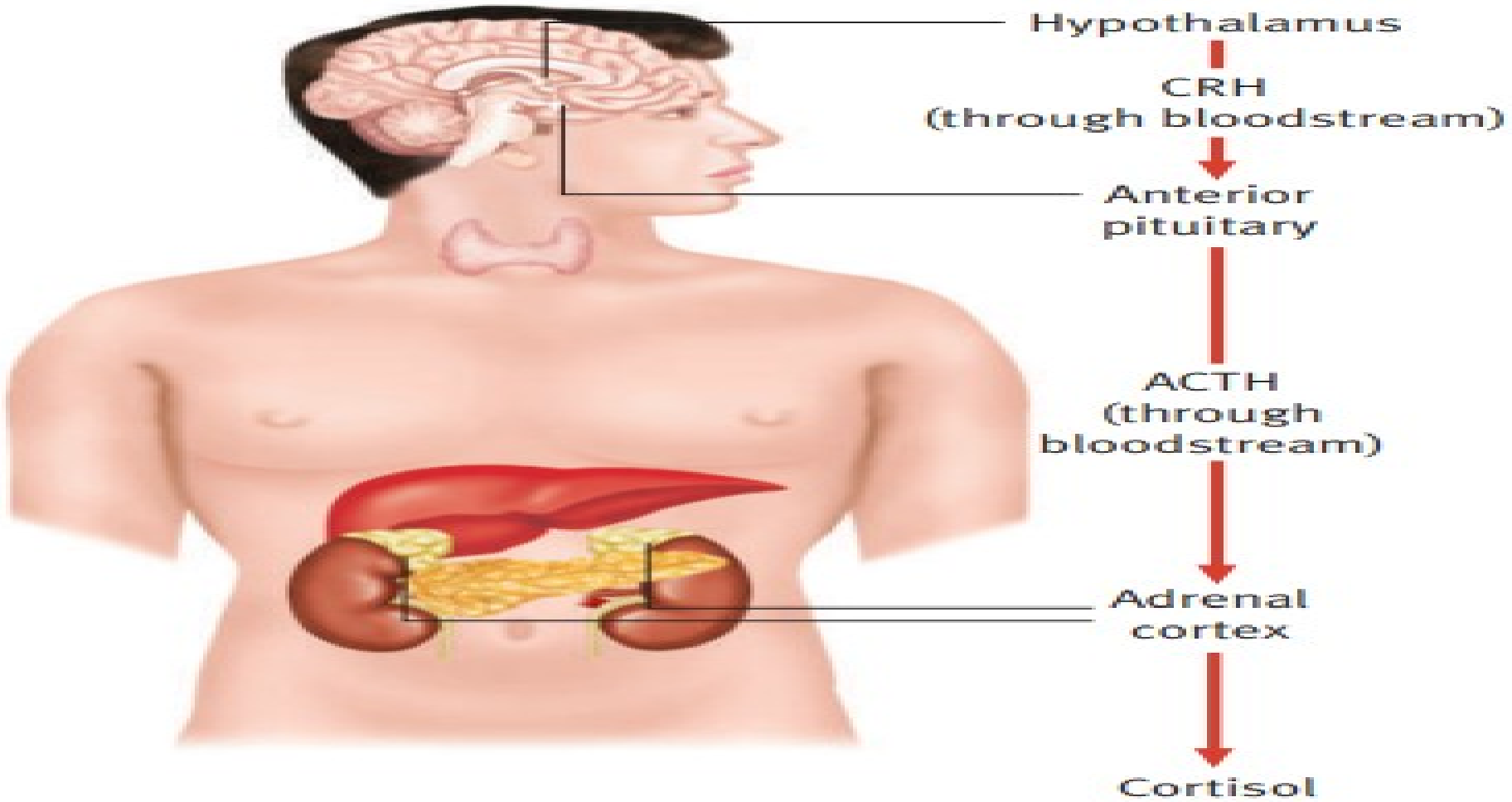
- **Stressors:**
- These are **external events or situations** that **create demands** on a person.
- **Stress:**
- This is the **internal psychological or physiological response** a person experiences due to a stressor.
- **Coping Strategies:**
- These are the **efforts or actions** a person takes to **manage stress**.

- The term stress tolerance refers to a person’s ability to withstand stress without becoming seriously impaired.
- Characteristics of Stressors:
- r. The key factors involve
- (1) the severity of the stressor,
- (2) its chronicity (i.e., how long it lasts),
- (3) its timing,
- (4) how closely it affects our own lives,
- (5) how expected it is, and
- (6) how controllable it is.

Stress and the Stress Response

- . The sympathetic-adrenomedullary (SAM):
- The stress response begins in the hypothalamus, which stimulates the sympathetic nervous system (SNS).
- This, in turn, causes the inner portion of the adrenal glands (the adrenal medulla) to
- secrete adrenaline (epinephrine) and noradrenaline (norepinephrine). As these circulate through the blood, they cause an increase in heart rate (familiar to all of us).
- They also get the body to metabolize glucose more rapidly.

e hypothalamus-pituitary-adrenal (HPA) system



- Psychoneuroimmunology is the study of the interaction between the nervous system and the immune system.
- Understanding the Immune System:
- The word immune comes from the Latin immunis, which means “exempt.” The immune system protects the body from such things as viruses and bacteria.
- The front line of defense in the immune system is the white blood cells. These leukocytes (or lymphocytes) are produced in the bone marrow and then stored in various places throughout the body, such as the spleen and the lymph nodes.

- There are two important types of leukocytes.
- One type, called a B-cell (because it matures in the bone marrow) produces specific antibodies that are designed to respond to specific antigens.
- The second important type of leukocyte is the T-cell (so named because it matures in the thymus, which is an important endocrine gland).
- Destroy infected or cancerous cells directly; also help B-cells function.

cytokines

- Cytokines are small protein molecules that serve as chemical messengers and allow immune cells to communicate with each other.

Type	Function
Pro-inflammatory	Promote inflammation (e.g., **IL-6, TNF-α**) – help fight infection but may also harm brain and body when too high
Anti-inflammatory	Reduce inflammation and promote healing (e.g., **IL-10**)

- An adjustment disorder is a psychological response to a common stressor (e.g., divorce, death of a loved one, loss of a job) that results in clinically significant behavioral or emotional symptoms.

- Acute stress disorder is a diagnostic category that can be used when symptoms develop shortly after experiencing a traumatic event and last for at least 2 days.
- **PTSD** is a **mental health disorder** that develops in some people after they experience or witness a **traumatic.**

. In DSM-5, the clinical symptoms of PTSD are grouped into four main areas

- Intrusion: Recurrent reexperiencing of the traumatic event through nightmares, intrusive images, and physiological reactivity to reminders of the trauma.
- Avoidance: Avoidance of thoughts, feelings or reminders of the trauma.
- Negative cognitions and mood: This includes such symptoms as feelings of detachment.
- Arousal and reactivity: Hypervigilance, excessive response when startled, aggression, and reckless behavior.

Chapter 3 Anxiety

- Anxiety involves a general feeling of apprehension about possible future danger.
- fear is an alarm reaction that occurs in response to immediate danger

- A **panic attack** is a **sudden, intense burst of fear or discomfort** that occurs **without any real, external danger**.
  It often **feels life-threatening**, but there is **no actual threat** present.

fear and panic have three components:

- cognitive/subjective components (“I feel afraid/terrified”; “I’m going to die”)
- physiological components (such as increased heart rate and heavy breathing)
- behavioral components (a strong urge to escape or flee;

Anxiety disorders

- Anxiety disorders all have unrealistic, irrational fears or anxieties of disabling intensity as their principal and most obvious manifestation. Among the disorders recognized in DSM-5 are:
- 1. specific phobia
- 2. social anxiety disorder (social phobia)
- 3. panic disorder
- 4. agoraphobia
- 5. generalized anxiety disorder

- A person is diagnosed as having a specific phobia if she or he shows strong and persistent fear that is triggered by the presence of a specific object or situation.

TABLE 6.1
Subtypes of Specific Phobias in *DSM-5*

Phobia Type	Examples
Animal	Snakes, spiders, dogs, insects, birds
Natural Environment	Storms, heights, water
Blood-Injection-Injury	Seeing blood or an injury, receiving an injection, seeing a person in a wheelchair
Situational	Public transportation, tunnels, bridges, elevators, flying, driving, enclosed spaces
Other	Choking, vomiting, "space phobia" (fear of falling down if away from walls or other support)

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- A form of behavior therapy called exposure therapy—which is the best treatment for specific phobias—involves controlled exposure to the stimuli or situations that elicit phobic fear.

Social Phobia

- **Social Phobia**, now officially called **Social Anxiety Disorder (SAD)**, is a **persistent, intense fear of social or performance situations** where the individual is exposed to possible **scrutiny by others**.
- More recently, as research has revealed the underlying distorted cognitions that characterize social phobia, cognitive restructuring techniques have been added to the behavioral techniques, generating a form of cognitive-behavioral therapy

- panic disorder is defined and characterized by the occurrence of panic attacks that often seem to come “out of the blue.
- Three are cognitive:
- (1) depersonalization (a feeling of being detached from one’s body) or derealization (a feeling that the external world is strange or unreal)
- (2) fear of dying
- (3) fear of “going crazy” or “losing control”

Agoraphobia

- Historically, agoraphobia was thought to involve a fear of the agora—the Greek word for public places of assembly (Marks, 1987). In agoraphobia the most commonly feared and avoided situations include streets and crowded places such as shopping malls, movie

A. Marked fear or anxiety about two (or more) of the following five situations:

1. Using public transportation (e.g., automobiles, buses, trains, ships, planes).
2. Being in open spaces (e.g., parking lots, marketplaces, bridges).
3. Being in enclosed places (e.g., shops, theaters, cinemas).
4. Standing in line or being in a crowd.
5. Being outside of the home alone.

- today it is recognized that it is increased activity in the amygdala that plays a more central role in panic attacks than does activity in the locus coeruleus.

criteria for
Generalized Anxiety Disorder

A. Excessive anxiety and worry (apprehensive expectation), occurring more days than not for at least 6 months, about a number of events or activities (such as work or school performance).

B. The individual finds it difficult to control the worry.

C. The anxiety and worry are associated with three (or more) of the following six symptoms (with at least some symptoms having been present for more days than not for the past 6 months):

Note: Only one item is required in children.

1. Restlessness or feeling keyed up or on edge.
2. Being easily fatigued.
3. Difficulty concentrating or mind going blank.
4. Irritability.
5. Muscle tension.
6. Sleep disturbance (difficulty falling or staying asleep, or restless, unsatisfying sleep).

- A Functional Deficiency in GABA.
- The Corticotropin-Releasing Hormone System and Anxiety

क्रम	विकार का नाम	आसान मतलब	मुख्य लक्षण
1	**Obsessive-Compulsive Disorder (OCD)**	बार-बार अनचाहे विचार (obsession) और उन्हें दूर करने के लिए दोहराए गए काम (compulsion)	बार-बार हाथ धोना, चीज़ें गिनना, ताले चेक करना आदि
2	**Body Dysmorphic Disorder (BDD)**	अपने शरीर/चेहरे में छोटी या काल्पनिक कमी को लेकर ज़रूरत से ज़्यादा चिंता	आईने में बार-बार देखना, छिपाने की कोशिश, सर्जरी की इच्छा
3	**Hoarding Disorder**	फालतू चीज़ों को फेंकने में कठिनाई, चीज़ें इकट्ठा करते रहना	घर में बेकार चीज़ों का ढेर, अव्यवस्था, दूसरों को परेशानी
4	**Trichotillomania** (Hair-Pulling Disorder)	तनाव या चिंता की स्थिति में बार-बार बाल तोड़ना	सिर, भौंह या पलकों के बाल खींचना, गंजापन
5	**Excoriation Disorder** (Skin-Picking Disorder)	बार-बार त्वचा नोचना जिससे घाव बन जाए	चेहरा, हाथ या शरीर पर बार-बार खरोंचना, घाव होना
6	**Substance/Medication-Induced OCD and Related Disorder**	किसी दवा या नशे के कारण OCD जैसे लक्षण आना	किसी दवा या नशा लेने के बाद OCD के लक्षण दिखना
7	**OCD and Related Disorder Due to Another Medical Condition**	किसी शारीरिक बीमारी की वजह से OCD जैसे लक्षण	जैसे – मिर्गी, ब्रेन इंजरी के बाद OCD जैसे व्यवहार

criteria for

Obsessive-Compulsive Disorder

DSM-5

A. Presence of obsessions, compulsions, or both:
Obsessions are defined by (1) and (2):

1. Recurrent and persistent thoughts, urges, or images that are experienced, at some time during the disturbance, as intrusive and unwanted, and that in most individuals cause marked anxiety or distress.
2. The individual attempts to ignore or suppress such thoughts, urges, or images, or to neutralize them with some other thought or action (i.e., by performing a compulsion).

Compulsions are defined by (1) and (2):

1. Repetitive behaviors (e.g., hand washing, ordering, checking) or mental acts (e.g., praying, counting, repeating words silently) that the individual feels driven to perform in response to an obsession or according to rules that must be applied rigidly.
2. The behaviors or mental acts are aimed at preventing or reducing anxiety or distress, or preventing some dreaded event or situation; however, these behaviors or mental acts are not connected in a realistic way with what they are designed to neutralize or prevent, or are clearly excessive.

Note: Young children may not be able to articulate the aims of these behaviors or mental acts.

B. The obsessions or compulsions are time-consuming (e.g., take more than 1 hour per day) or cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.

C. The obsessive-compulsive symptoms are not attributable to the physiological effects of a substance (e.g., a drug of abuse, a medication) or another medical condition.

D. The disturbance is not better explained by the symptoms of another mental disorder (e.g., excessive worries, as in generalized anxiety disorder; preoccupation with appearance, as in body dysmorphic disorder; difficulty discarding or parting with possessions, as in hoarding disorder; hair pulling, as in trichotillomania [hair-pulling disorder]; skin picking, as in excoriation [skin-picking] disorder; stereotypies, as in stereotypic movement disorder; ritualized eating behavior, as in eating disorders; preoccupation with substances or gambling, as in substance-related and addictive disorders; preoccupation with having an illness, as in illness anxiety disorder; sexual urges or fantasies, as in paraphilic disorders; impulses, as in disruptive, impulse-control, and conduct disorders; guilty ruminations, as in major depressive disorder; thought insertion or delusional preoccupations, as in schizophrenia spectrum and other psychotic disorders; or repetitive patterns of behavior, as in autism spectrum disorder).

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A behavioral treatment that combines exposure and response prevention seems be the most effective approach to treating obsessive-compulsive disorders

Brain Area	Function	OCD Abnormality
Orbital Frontal Cortex	Decision-making, threat detection	Overactive in OCD → intrusive thoughts
Cingulate Cortex (Gyrus)	Error detection, emotional regulation	Overactive → anxiety, need to "fix" things
Caudate Nucleus (part of Basal Ganglia)	Movement, habit formation, filtering thoughts	Fails to filter unwanted thoughts → compulsions
Basal Ganglia	Motor control, routine behaviors	Hyperactive circuits → repetitive rituals
Amygdala	Emotion processing	Links with OCD fear responses, especially disgust (e.g., dirt, germs)

chapter 4 Mood Disorders: An Overview

- The two key moods involved in mood disorders are mania, often characterized by intense and unrealistic feelings of excitement and euphoria, and
- depression, which usually involves feelings of extraordinary sadness and dejection.

Types of Mood Disorders

- the unipolar depressive disorders, in which the person experiences only depressive episodes,
- bipolar and related disorders, in which the person experiences both manic and depressive episodes.

criteria for
Major Depressive Disorder

DSM-5

A. Five (or more) of the following symptoms have been present during the same 2-week period and represent a change from previous functioning; at least one of the symptoms is either (1) depressed mood or (2) loss of interest or pleasure.

Note: Do not include symptoms that are clearly attributable to another medical condition.

1. Depressed mood most of the day, nearly every day, as indicated by either subjective report (e.g., feels sad, empty, or hopeless) or observation made by others (e.g., appears tearful). (**Note:** In children and adolescents, can be irritable mood.)
2. Markedly diminished interest or pleasure in all, or almost all, activities most of the day, nearly every day (as indicated by either subjective account or observation).
3. Significant weight loss when not dieting or weight gain (e.g., a change of more than 5% of body weight in a month), or decrease or increase in appetite nearly every day. (**Note:** In children, consider failure to make expected weight gain.)
4. Insomnia or hypersomnia nearly every day.
5. Psychomotor agitation or retardation nearly every day (observable by others; not merely subjective feelings of restlessness or being slowed down).
6. Fatigue or loss of energy nearly every day.
7. Feelings of worthlessness or excessive or inappropriate guilt (which may be delusional) nearly every day (not merely self-reproach or guilt about being sick).
8. Diminished ability to think or concentrate, or indecisiveness, nearly every day (either by subjective account or as observed by others).
9. Recurrent thoughts of death (not just fear of dying), recurrent suicidal ideation without a specific plan, or a suicide attempt or a specific plan for committing suicide.

B. The symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.

C. The episode is not attributable to the physiological effects of a substance or another medical condition.

Note: Criteria A–C constitute a major depressive episode. Major depressive episodes are common in bipolar I disorder but are not required for the diagnosis of bipolar I disorder.

Note: Responses to a significant loss (e.g., bereavement, financial ruin, losses from a natural disaster, a serious medical illness or disability) may include the feelings of intense sadness, rumination about the loss, insomnia, poor appetite, and weight loss noted in Criterion A, which may resemble a depressive episode. Although such symptoms may be understandable or considered appropriate to the loss, the presence of a major depressive episode in addition to the normal response to a significant loss should also be carefully considered. This decision inevitably requires the exercise of clinical judgment based on the individual's history and the cultural norms for the expression of distress in the context of loss.

D. The occurrence of the major depressive episode is not better explained by schizoaffective disorder, schizophrenia, schizophreniform disorder, delusional disorder, or other specified and unspecified schizophrenia spectrum and other psychotic disorders.

E. There has never been a manic episode or a hypomanic episode.

Note: This exclusion does not apply if all of the manic-like or hypomanic-like episodes are substance-induced or are attributable to the physiological effects of another medical condition.

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criteria for
Manic Episode

DSM-5

A. A distinct period of abnormally and persistently elevated, expansive, or irritable mood and abnormally and persistently increased goal-directed activity or energy, lasting at least 1 week and present most of the day, nearly every day (or any duration if hospitalization is necessary).

B. During the period of mood disturbance and increased energy or activity, three (or more) of the following symptoms (four if the mood is only irritable) are present to a significant degree and represent a noticeable change from usual behavior:

1. Inflated self-esteem or grandiosity.
2. Decreased need for sleep (e.g., feels rested after only 3 hours of sleep).
3. More talkative than usual or pressure to keep talking.
4. Flight of ideas or subjective experience that thoughts are racing.
5. Distractibility (i.e., attention too easily drawn to unimportant or irrelevant external stimuli), as reported or observed.
6. Increase in goal-directed activity (either socially, at work or school, or sexually) or psychomotor agitation (i.e., purposeless non-goal-directed activity).
7. Excessive involvement in activities that have a high potential for painful consequences (e.g., engaging in unrestrained buying sprees, sexual indiscretions, or foolish business investments).

C. The mood disturbance is sufficiently severe to cause marked impairment in social or occupational functioning or to necessitate hospitalization to prevent harm to self or others, or there are psychotic features.

D. The episode is not attributable to the physiological effects of a substance (e.g., a drug of abuse, a medication, other treatment) or to another medical condition.

Note: A full manic episode that emerges during antidepressant treatment (e.g., medication, electroconvulsive therapy) but persists at a fully syndromal level beyond the physiological effect of that treatment is sufficient evidence for a manic episode and, therefore, a bipolar I diagnosis.

Note: Criteria A–D constitute a manic episode. At least one lifetime manic episode is required for the diagnosis of bipolar I disorder.

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Feature	Unipolar Depression	Bipolar Disorder
Mood Episode Type	Only depressive episodes	Both manic/hypomanic and depressive
Energy Level	Low	Alternates between high (mania) and low
Sleep Pattern	Insomnia or oversleeping	Decreased need for sleep during mania
Prevalence	More common	Less common
Onset	Often later (20s–30s)	Earlier (late teens–20s)
Risk of Suicide	High	Higher than unipolar in many cases
Example Disorders	MDD, Dysthymia	Bipolar I, Bipolar II, Cyclothymia

Grief

- Grief often has certain characteristic qualities. Indeed, Bowlby's (1980) classic observations revealed that there are usually four phases of normal response to the loss of a spouse or close family member.
- : (1) numbing and disbelief
- , (2) yearning and searching for the dead person,
- (3) disorganization and despair that sets in when the person accepts the loss as permanent, and
- (4) some reorganization as the person gradually begins to rebuild his or her life

Dysthymic Disorder (Persistent Depressive Disorder)

- **Persistent Depressive Disorder (PDD)** is a **chronic form of depression** where a person experiences a **depressed mood for most of the day, for at least 2 years** (1 year for children/adolescents), but symptoms are usually **less severe** than major depressive episodes.

Specifiers for Major Depressive Episode

- One such specifier is major depressive episode with melancholic features.
- a patient either has lost interest or pleasure in almost all activities or does not react to usually pleasurable stimuli or desired events
- severe major depressive episode with psychotic features.
- Psychotic symptoms, characterized by loss of contact with reality and delusions (false beliefs) or hallucinations (false sensory perceptions)
- Major depressive episode with atypical features

TABLE 7.1
Specifiers of Major Depressive Episodes

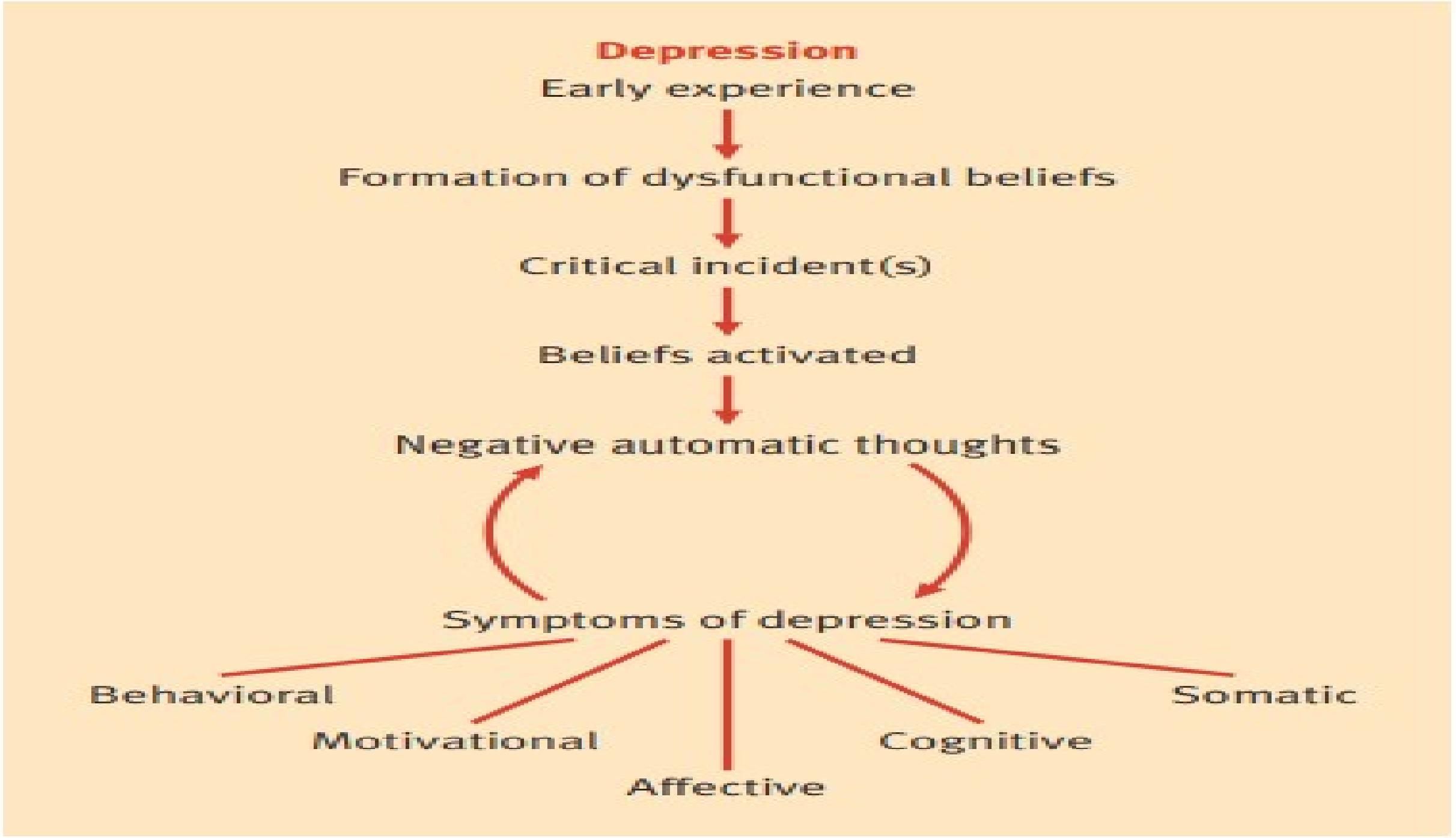
Specifier	Characteristic Symptoms
With Melancholic Features	Three of the following: Early morning awakening, depression worse in the morning, marked psychomotor agitation or retardation, loss of appetite or weight, excessive guilt, qualitatively different depressed mood.
With Psychotic Features	Delusions or hallucinations (usually mood congruent); feelings of guilt and worthlessness common.
With Atypical Features	Mood reactivity—brightens to positive events; two of the four following symptoms: weight gain or increase in appetite, hypersomnia, leaden paralysis (arms and legs feel as heavy as lead), being acutely sensitive to interpersonal rejection.
With Catatonic Features	A range of psychomotor symptoms from motoric immobility to extensive psychomotor activity, as well as mutism and rigidity.
With Seasonal Pattern	At least two or more episodes in past 2 years that have occurred at the same time (usually fall or winter), and full remission at the same time (usually spring). No other nonseasonal episodes in the same 2-year period.

📋 Summary Table: Depression & Brain Areas

Brain Area	Abnormality in Depression	Function Affected
Left Prefrontal Cortex	Low activity	↓ Positive emotion, reward-seeking
Right Prefrontal Cortex	High activity	↑ Anxiety, vigilance to threat
Dorsolateral Prefrontal Cortex	Hypoactivity	↓ Executive function, emotion regulation
Orbital Prefrontal Cortex	Reduced volume	↓ Reward responsiveness, anhedonia

Beck’s Cognitive Theory

- Beck hypothesized that the cognitive symptoms of depression often precede and cause the affective or mood symptoms rather than vice versa.
- Beck’s theory, a diathesis-stress theory in which negative cognitions are central, has become somewhat more elaborate over the years while still retaining its primary tenets.


Depression
Early experience
Formation of dysfunctional beliefs
Critical incident(s)
Beliefs activated
Negative automatic thoughts
Symptoms of depression
Behavioral
Motivational
Affective
Cognitive
Somatic

- First, there are the underlying dysfunctional beliefs, known as depressogenic schemas, which are rigid, extreme, and counterproductive.
- “If everyone doesn’t love me, then my life is worthless.

negative automatic thoughts

- negative automatic thoughts—thoughts that often occur just below the surface of awareness and involve unpleasant, pessimistic predictions.
- These pessimistic predictions tend to center on the three themes of what Beck calls the negative cognitive triad:
- (1) negative thoughts about the self (“I’m ugly”; “I’m worthless”; “I’m a failure”);
- (2) negative thoughts about one’s experiences and the surrounding world (“No one loves me”; “People treat me badly”); and
- (3) negative thoughts about one’s future (“It’s hopeless because things will always be this way

The Reformulated Helplessness Theory

- In particular, Abramson and colleagues proposed that when people (probably unlike animals) are exposed to uncontrollable negative events, they ask themselves why, and the kinds of attributions that people make are, in turn, central to whether they become depressed.
- These investigators proposed three critical dimensions on which attributions are made: (1) internal/external, (2) global/specific, and (3) stable/unstable.

- e. They proposed that a depressogenic or pessimistic attribution for a negative event is an internal, stable, and global one.

🔍 Pessimistic Attributional Style:

When explaining negative events, a **depressed person** tends to use **three maladaptive dimensions**:

Dimension	Type	Example	Effect
Internal vs. External	Internal	"It's my fault"	Self-blame
Stable vs. Unstable	Stable	"It will always be this way"	Hopelessness
Global vs. Specific	Global	"I fail at everything"	Generalized low self-worth

This is called the **ISG model** (**Internal, Stable, Global**).

The Hopelessness Theory of Depression

- Depression is most likely to occur when a person **expects negative outcomes** and **believes they are helpless to change them** — leading to

🧱 3 गलत सोच (Attribution Style) जो डिप्रेशन बढ़ाती है:

सोच का प्रकार	उदाहरण	असर
Internal (**आंतरिक**)	"यह मेरी गलती है।"	Self-blame (आत्म-दोष)
Stable (**स्थायी**)	"यह हमेशा रहेगा।"	उम्मीद की कमी
Global (**सार्वभौमिक**)	"मैं हर चीज़ में फेल हूं।"	पूरी ज़िंदगी पर असर

Nolen-Hoeksema’s ruminative response style cognitive theory of depression

- ome people cope with **negative mood** by **repeatedly thinking about it** — this is called **rumination**.
  The more you ruminate, the **worse and longer your depression** becomes

Bipolar and Related Disorders

Disorder	Features
Bipolar I Disorder	At least 1 **manic episode** (may have depression too)
Bipolar II Disorder	At least 1 **hypomanic episode** + 1 **major depressive episode**, but **no full mania**
Cyclothymic Disorder	Mild mood swings – ups (hypomania-like) and downs (mild depression) for **2 years**
Substance/Medication-Induced Bipolar	Mood shifts caused by drugs or medication
Bipolar due to Medical Condition	Mood changes due to physical illness (like brain injury, thyroid issues)

Treatment

- electroconvulsive therapy (ECT) is often used with severely depressed patients.
- Transcranial Magnetic Stimulation (TMS)
- Deep Brain Stimulation
- Bright Light Therapy

Somatic Symptom and Related Disorders

- In malingering the person is intentionally producing or grossly exaggerating physical symptoms and is motivated by external incentives such as avoiding work or military service or evading criminal prosecution.

Somatic Symptom and Related Disorders

- somatic symptom disorder; Physical symptoms like pain or fatigue that **cause distress**, with **excessive thoughts or anxiety** about them.
- on there being at least one of the following three features:
- (1) disproportionate and persistent thoughts about the seriousness of one's symptoms;
- (2) persistently high level of anxiety about health or symptoms; and/or
- (3) excessive time and energy devoted to these symptoms or health concerns

Hypochondriasis or illness anxiety disorder

- Person has **intense fear of having a serious illness**, **even without major symptoms** Hypochondriasis or illness anxiety disorder

- Person has **neurological symptoms** (e.g., paralysis, blindness, seizures) but **no medical cause.** conversion disorder;

- Factitious Disorder: Person **deliberately fakes or causes symptoms** to assume the “sick role” — **without any clear benefit** (like money)

Freud's Theory: Conversion Hysteria (Now: Conversion Disorder)

- Freud believed that some people have **unconscious sexual or emotional conflicts** (especially from childhood).
- These conflicts create **anxiety**, but since the mind cannot express them openly, the anxiety gets **converted into physical symptoms** (like paralysis, blindness, etc.) — without any physical cause.

Concept	Meaning
Primary gain	Physical symptom reduces internal anxiety (e.g., conflict is avoided)
Secondary gain	Person gets external benefits (e.g., attention, care)
Repression	Unconscious blocking of distressing desires
Conversion	Unconscious transformation of anxiety into physical symptoms

Dissociative Disorders

- Dissociative disorders are a group of conditions involving disruptions in a person's normally integrated functions of consciousness, memory, identity, or perception.
- Two of the more common kinds of dissociative symptoms are derealization and depersonalization.
- In derealization one's sense of the reality of the outside world is temporarily lost,
- depersonalization one's sense of one's own self and one's own reality is temporarily lost.

Disorder	Key Feature	Example
Dissociative Amnesia	Memory loss (personal info)	Cannot remember past trauma
Fugue	Travel + new identity	Found in another city with no memory
DID	2+ personalities	"John" and "David" in same body
Depersonalization/Derealization	Feeling detached from self/environment	"It's like I'm watching my life from outside."

- dissociative amnesia is usually limited to a failure to recall previously stored personal information.
- a dissociative fugue, which, as the term implies (the French word fugue means “flight”), is a defense by actual flight—a person is not only amnesic for some or all aspects of his or her past but also departs from home surroundings.
- Dissociative identity disorder (DID), formerly known as multiple personality disorder is a dramatic dissociative disorder in which a patient manifests two or more distinct identities that alternate in some way in taking control of behavior.

Chapter 5 Eating disorder

- eating disorders are characterized by a persistent disturbance in eating behavior.
- The term anorexia nervosa literally means “lack of appetite induced by nervousness.”
- At the heart of anorexia nervosa is an intense fear of gaining weight or becoming fat, combined with behaviors that result in a significantly low body weight.

- There are two types of anorexia nervosa: the restricting type and the binge-eating/purging type.
- . In the restricting type, every effort is made to limit the quantity of food consumed. Caloric intake is tightly controlled. Patients often try to avoid eating in the presence of other people.

- A binge involves an out-of-control consumption of an amount of food that is far greater than what most people would eat in the same amount of time and under the same circumstances.
- These binges may be followed by efforts to purge, or remove from their bodies, the food they have eaten. Methods of purging commonly include self-induced vomiting or misusing laxatives, diuretics, and enemas

Bulimia nervosa

- Bulimia nervosa is characterized by uncontrollable binge eating and efforts to prevent resulting weight gain by using inappropriate behaviors such as self-induced vomiting and excessive exercise
- Bulimia nervosa was recognized as a psychiatric syndrome relatively recently.
- The British psychiatrist G. F. M. Russell (1997) proposed the term in 1979.

Binge-Eating Disorder

- **Binge-Eating Disorder** □□ □□□ □□□□□□ □□□□□ □□ □□□□□□ □□□□□□□ □□□-□□□ □□□□ □□□□□□□ □□□□ □□ □□□□ □□, □□□□ □□□ □□, □□ □□□□ □□□ □□□□□□ □□ □□□□□□□□□ □□□□□ □□□□ □□□ □□□□□□ □□ □□□□ □□ □□□ □□□ □□□□□ □□□□ □□□□□□ □□□□ □□ □□□□□ □□□□ □□ □□□ □□□□

- An area of the brain that plays an important role in eating is the hypothalamus.
- There is a well-established tendency for our bodies to resist marked variation from some sort of biologically determined set point or weight that our individual bodies try to “defend”
- Serotonin is a neurotransmitter that has been implicated in obsessionally, mood disorders, and impulsivity. It also modulates appetite and feeding behavior.

- People with anorexia nervosa have low levels of 5-HIAA, which is a major metabolite of serotonin. This may be because they are eating so little food.
- . In contrast, levels of 5-HIAA are normal in people with bulimia nervosa.

- Obesity is defined on the basis of a statistic called the body mass index (BMI). This is a measure of a person’s weight relative to height and is calculated using the formula

Hormone	Origin	Effect on Appetite	Notes
Leptin	Fat cells	↓ Decrease	Leptin resistance in obesity
Ghrelin	Stomach	↑ Increase	Rises before meals
Insulin	Pancreas	↓ (indirectly)	Also promotes fat storage
CCK	Small intestine	↓ Decrease	Promotes fullness
PYY	Colon	↓ Decrease	Reduced in obesity
Cortisol	Adrenal glands	↑ Increase	Stress-related eating
NPY	Hypothalamus	↑ Strong increase	Released in starvation

- Prader–Willi Syndrome is a **genetic disorder** caused by the **absence of specific genes on chromosome 15 (paternal)**.
  It leads to:
- **Insatiable hunger**
- **Obesity**
- **Intellectual disability**
- **Behavioral problems**

Chapter 5 personality disorders

- Cognition
- Affectivity
- Personal (interpersonal) functioning
- Rigid (inflexible/pervasive)
- Impulse control

Cluster

- • Cluster A: Includes paranoid, schizoid, and schizotypal personality disorders. People with these disorders often seem odd or eccentric, with unusual behavior ranging from distrust and suspiciousness to social detachment.
- Cluster B: Includes histrionic, narcissistic, antisocial, and borderline personality disorders. Individuals with these disorders share a tendency to be dramatic, emotional, and erratic.
- • Cluster C: Includes avoidant, dependent, and obsessive-compulsive personality disorders. In contrast to the other two clusters, people with these disorders often show anxiety and fearfulness.

TABLE 10.1
Summary of Personality Disorders

Personality Disorder	Characteristics	Prevalence	Gender Ratio Estimate
Cluster A			
Paranoid	Suspiciousness and mistrust of others; tendency to see self as blameless; on guard for perceived attacks by others	0.5–2.5%	males > females
Schizoid	Impaired social relationships; inability and lack of desire to form attachments to others	<1%	males > females
Schizotypal	Peculiar thought patterns; oddities of perception and speech that interfere with communication and social interaction	3%	males > females
Cluster B			
Histrionic	Self-dramatization; over concern with attractiveness; tendency to irritability and temper outbursts if attention seeking is frustrated	2–3%	males = females
Narcissistic	Grandiosity; preoccupation with receiving attention; self-promoting; lack of empathy	<1%	males > females
Antisocial	Lack of moral or ethical development; inability to follow approved models of behavior; deceitfulness; shameless manipulation of others; history of conduct problems as a child	1% females, 3% males	males > females
Borderline	Impulsiveness; inappropriate anger; drastic mood shifts; chronic feelings of boredom; attempts at self-mutilation or suicide	2%	females = males
Cluster C			
Avoidant	Hypersensitivity to rejection or social derogation; shyness; insecurity in social interaction and initiating relationships	0.5–1%	males = females
Dependent	Difficulty in separating in relationships; discomfort at being alone; subordination of needs in order to keep others involved in a relationship; indecisiveness	2%	males = females
Obsessive-Compulsive	Excessive concern with order, rules, and trivial details; perfectionistic; lack of expressiveness and warmth; difficulty in relaxing and having fun	1%	males > females (by 2:1)

- Epidemiological studies are designed to establish the prevalence (number of cases) of a particular disorder in a very large sample (usually many thousands) of people living in the community.
- Dialectical behavior therapy, developed by Marsha Linehan, is a unique kind of cognitive and behavioral therapy specifically adapted for BPD.
- Finally, we note that there is one other promising treatment approach that deserves mention. Bateman and Fonagy have developed a new therapeutic approach called mentalization.

Substance related disorders

- The most commonly used problem substances are those that affect mental functioning in the central nervous system (CNS)— psychoactive substances: alcohol, nicotine, barbiturates, tranquilizers, amphetamines, heroin, Ecstasy, and marijuana.

- alcohol withdrawal delirium (formerly known as delirium tremens) This reaction usually happens following a prolonged drinking spree when the person enters a state of withdrawal.
- disorientation for time and place
- vivid hallucinations
- acute fear
- extreme suggestibility
- marked tremors

” The mesocorticolimbic dopamine pathway (MCLP) or Pleasure Pathway

VTA ➜ Nucleus Accumbens ➜ Prefrontal Cortex
(dopamine released → feeling of reward)

🧠 Main Brain Areas Involved:

Part of Pathway	Function
Ventral Tegmental Area (VTA)	Dopamine-producing neurons begin here
Nucleus Accumbens (NAc)	Processes reward, motivation, and reinforcement
Prefrontal Cortex (PFC)	Decision-making, self-control, planning

TABLE 11.2
Psychoactive Drugs Commonly Involved in Drug Abuse

Classification	Drug	Effect
Sedatives	Alcohol (ethanol)	Reduce tension Facilitate social interaction "Blot out" feelings or events
	Barbiturates	Reduce tension
	Nembutal (pentobarbital)	
	Seconal (secobarbital)	
	Veronal (barbital)	
	Tuinal (secobarbital and amobarbital)	
Stimulants	Amphetamines	Increase feelings of alertness and confidence
	Benzedrine (amphetamine)	
	Dexedrine (dextroamphetamine)	Decrease feelings of fatigue
	Methedrine (methamphetamine)	Stay awake for long periods
	Cocaine (coca)	Increase endurance Stimulate sex drive
Opiates	Opium and its derivatives	Alleviate physical pain
	Opium	Induce relaxation and pleasant reverie
	Morphine	Alleviate anxiety and tension
	Codeine	
	Heroin	
	Methadone (synthetic narcotic)	Treatment of heroin dependence
Hallucinogens	Cannabis	Induce changes in mood, thought, and behavior
	Marijuana	
	Hashish	
	Mescaline (peyote)	"Expand" one's mind
	Psilocybin (psychotogenic mushrooms)	Induce stupor
	LSD (lysergic acid diethylamide-25)	
	PCP (phencyclidine)	
Antianxiety drugs (minor tranquilizers)	Librium (chlordiazepoxide)	Alleviate tension and anxiety
	Miltown (meprobamate)	Induce relaxation and sleep
	Valium (diazepam)	
	Xanax	

sexual variants, abuse, and dysfunctions

- **Gender Dysphoria** is the **distress or discomfort** a person feels when their **gender identity** (how they feel inside) **does not match** their **assigned sex at birth**.

🧠 Common Paraphilic Disorders (DSM-5 Recognized):

Paraphilic Disorder	Description
Exhibitionistic Disorder	Urge to expose genitals to strangers
Voyeuristic Disorder	Watching others undress or engage in sex without consent
Frotteuristic Disorder	Touching or rubbing against non-consenting persons
Sexual Masochism Disorder	Being sexually aroused by being humiliated or hurt
Sexual Sadism Disorder	Arousal from causing pain or suffering
Pedophilic Disorder	Sexual interest in prepubescent children
Fetishistic Disorder	Use of nonliving objects (e.g., shoes, underwear)
Transvestic Disorder	Sexual arousal from cross-dressing (in heterosexual males)**only if distressing**

✅ Examples of Rare Paraphilias (Other Specified):

Name	Description
Telephone Scatologia	Sexual arousal from making **obscene phone calls**
Necrophilia	Sexual attraction to **corpses**
Zoophilia	Sexual interest in **animals**
Apotemnophilia	Sexual excitement about the **idea of having a limb amputated**
Coprophilia	Sexual arousal related to **feces**
Urophilia	Sexual arousal from **urine**
Klismaphilia	Sexual arousal from **enemas**

- Autogynephilia literally means: “love of oneself as a woman.” Coined by sexologist Ray Blanchard, it refers to a male's sexual arousal at the thought or image of himself as a woman.

Phase

- Masters and Johnson (1966, 1970, 1975) and Kaplan (1979). According to DSM-5, disorders can occur in any of the first three phases:
- The first phase is the desire phase, which consists of fantasies about sexual activity or a sense of desire to have sexual activity. •
- The second phase is the excitement (or arousal) phase, characterized both by a subjective sense of sexual pleasure
- The third phase is orgasm, during which there is a release of sexual tension and a peaking of sexual pleasure.
- The final phase is resolution, during which the person has a sense of relaxation and well-being.

Chapter 6 Schizophrenia

- **Schizophrenia** is a **chronic and severe mental disorder** that affects how a person **thinks, feels, and behaves**. People with schizophrenia may seem like

According to **DSM-5**, diagnosis requires **2 or more** of the following, present for **1 month**, and **at least one must be 1, 2, or 3**:

1. **Delusions** – false beliefs (e.g., someone is trying to harm me)
2. **Hallucinations** – false perceptions (e.g., hearing voices)
3. **Disorganized speech** – incoherent or illogical talking
4. **Disorganized or catatonic behavior** – bizarre or purposeless movements
5. **Negative symptoms** – flat affect, alogia (poverty of speech), avolition (lack of motivation)

📌 Positive vs Negative Symptoms

Positive Symptoms	Negative Symptoms
Hallucinations	Flat affect (no emotion)
Delusions	Alogia (lack of speech)
Disorganized speech	Avolition (lack of motivation)
Catatonia	Anhedonia (no pleasure)

- Delusions reflect a disorder of thought content.
- Disorganized speech, on the other hand, is the external manifestation of a disorder in thought form.

In consideration of this, the DSM-IV-TR

- paranoid schizophrenia (where the clinical picture is dominated by absurd and illogical beliefs that are often highly elaborated and organized into a coherent, though delusional, framework)
- disorganized schizophrenia (which is characterized by disorganized speech, disorganized behavior, and flat or inappropriate affect)
- catatonic schizophrenia (which involves pronounced motor signs that reflect great excitement or stupor)

Other Psychotic Disorders

- Schizoaffective Disorder. An uninterrupted period of illness during which there is a major mood episode (major depressive or manic) concurrent with Criterion A of schizophrenia
- **Schizophreniform Disorder**
- **Symptoms** similar to schizophrenia
- **Duration**: **More than 1 month but less than 6 months**
- **Delusional Disorder**
- Presence of **non-bizarre delusions** (things that could happen in real life, like being followed)
- Duration: **At least 1 month**

- **Brief Psychotic Disorder**
- Sudden onset of **psychotic symptoms** (delusions, hallucinations, etc.)
- **Duration**: **At least 1 day, but less than 1 month**

Parkinson’s Disease

- Named after James Parkinson, who first described it in 1817, Parkinson’s disease.
- Parkinson’s disease is characterized by motor symptoms such as resting tremors or rigid movements. The underlying cause of this is loss of dopamine neurons in an area of the brain called the substantia nigra.
- Parkinson’s disease can involve psychological symptoms such as depression, anxiety, apathy, cognitive problems, and even hallucinations and delusions

Huntington’s disease

- Huntington’s disease is a rare degenerative disorder of the central nervous system that afflicts about 1 in every 10,000 people. It was first described in 1872 by the American neurologist George Huntington.
- Huntington’s disease is characterized by a chronic, progressive chorea (involuntary and irregular movements that flow randomly from one area of the body to another)
- **Genetic Basis:**
  Caused by a **CAG trinucleotide repeat expansion** in the **HTT gene** on **chromosome 4**.

⚠️ Core Symptoms

Domain	Symptoms
Motor	Chorea (involuntary jerky movements), dystonia, poor coordination, difficulty walking/swallowing
Cognitive	Poor concentration, memory loss, impaired judgment, executive dysfunction
Psychiatric	Depression, irritability, apathy, anxiety, obsessive-compulsive behaviors, psychosis
Functional Decline	Progressive loss of independence and daily function

Alzheimer’s disease

- is a progressive and fatal neurodegenerative disorder. It takes its name from Alois Alzheimer (1864–1915), the German neuropathologist who first described it in 1907.
- . It is the most common cause of dementia.

🧪 Etiology & Risk Factors

Type	Description
Early-onset	Rare (<5%), before age 65, often familial/genetic (e.g., mutations in APP, PSEN1, PSEN2 genes)
Late-onset	Common (>95%), typically after age 65, influenced by **APOE-ε4 gene**, age, environment
Risk factors	Age, family history, low education, head trauma, vascular issues, sedentary lifestyle

🧬 Pathophysiology

Feature	Explanation
Amyloid plaques	Extracellular deposits of **beta-amyloid** protein that interfere with neuronal communication
Neurofibrillary tangles	Intracellular accumulations of **hyperphosphorylated tau protein** that disrupt cell structure
Neurotransmitter deficit	Marked reduction in **acetylcholine**
Brain changes	Atrophy, especially in **hippocampus**, **entorhinal cortex**, and later in the **cerebral cortex**

criteria for
Conduct Disorder

DSM-5

A. A repetitive and persistent pattern of behavior in which the basic rights of others or major age-appropriate societal norms or rules are violated, as manifested by the presence of at least three of the following 15 criteria in the past 12 months from any of the categories below, with at least one criterion present in the past 6 months:

Aggression to People and Animals

1. Often bullies, threatens, or intimidates others.
2. Often initiates physical fights.
3. Has used a weapon that can cause serious physical harm to others (e.g., a bat, brick, broken bottle, knife, gun).
4. Has been physically cruel to people.
5. Has been physically cruel to animals.
6. Has stolen while confronting a victim (e.g., mugging, purse snatching, extortion, armed robbery).
7. Has forced someone into sexual activity.

Destruction of Property

8. Has deliberately engaged in fire setting with the intention of causing serious damage.
9. Has deliberately destroyed others' property (other than by fire setting).

Deceitfulness or Theft

10. Has broken into someone else's house, building, or car.
11. Often lies to obtain goods or favors or to avoid obligations (i.e., "cons" others).
12. Has stolen items of nontrivial value without confronting a victim (e.g., shoplifting, but without breaking and entering; forgery).

Serious Violations of Rules

13. Often stays out at night despite parental prohibitions, beginning before age 13 years.
14. Has run away from home overnight at least twice while living in the parental or parental surrogate home, or once without returning for a lengthy period.
15. Is often truant from school, beginning before age 13 years.

B. The disturbance in behavior causes clinically significant impairment in social, academic, or occupational functioning.

C. If the individual is age 18 years or older, criteria are not met for antisocial personality disorder.

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criteria for
Attention-Deficit/Hyperactivity Disorder

DSM-5

A. A persistent pattern of inattention and/or hyperactivity-impulsivity that interferes with functioning or development, as characterized by (1) and/or (2):

1. **Inattention:** Six (or more) of the following symptoms have persisted for at least 6 months to a degree that is inconsistent with developmental level and that negatively impacts directly on social and academic/occupational activities:

   Note: The symptoms are not solely a manifestation of oppositional behavior, defiance, hostility, or failure to understand tasks or instructions. For older adolescents and adults (age 17 and older), at least five symptoms are required.

   a. Often fails to give close attention to details or makes careless mistakes in schoolwork, at work, or during other activities (e.g., overlooks or misses details, work is inaccurate).

   b. Often has difficulty sustaining attention in tasks or play activities (e.g., has difficulty remaining focused during lectures, conversations, or lengthy reading).

   c. Often does not seem to listen when spoken to directly (e.g., mind seems elsewhere, even in the absence of any obvious distraction).

   d. Often does not follow through on instructions and fails to finish schoolwork, chores, or duties in the workplace (e.g., starts tasks but quickly loses focus and is easily sidetracked).

   e. Often has difficulty organizing tasks and activities (e.g., difficulty managing sequential tasks; difficulty keeping materials and belongings in order; messy, disorganized work; has poor time management; fails to meet deadlines).

   f. Often avoids, dislikes, or is reluctant to engage in tasks that require sustained mental effort (e.g., schoolwork or homework; for older adolescents and adults, preparing reports, completing forms, reviewing lengthy papers).

2. **Hyperactivity and impulsivity:** Six (or more) of the following symptoms have persisted for at least 6 months to a degree that is inconsistent with developmental level and that negatively impacts directly on social and academic/occupational activities:

   Note: The symptoms are not solely a manifestation of oppositional behavior, defiance, hostility, or a failure to understand tasks or instructions. For older adolescents and adults (age 17 and older), at least five symptoms are required.

   a. Often fidgets with or taps hands or feet or squirms in seat.

   b. Often leaves seat in situations when remaining seated is expected (e.g., leaves his or her place in the classroom, in the office or other workplace, or in other situations that require remaining in place).

   c. Often runs about or climbs in situations where it is inappropriate. **(Note:** In adolescents or adults, may be limited to feeling restless.)

   d. Often unable to play or engage in leisure activities quietly.

   e. Is often "on the go," acting as if "driven by a motor" (e.g., is unable to be or uncomfortable being still for extended time, as in restaurants, meetings; may be experienced by others as being restless or difficult to keep up with).

   f. Often talks excessively.

   g. Often blurts out an answer before a question has been completed (e.g., completes people's sentences; cannot wait for turn in conversation).

   h. Often has difficulty waiting his or her turn (e.g., while waiting in line).

   i. Often interrupts or intrudes on others (e.g., butts into conversations, games, or activities; may start using other people's things without asking or receiving permission; for adolescents and adults, may intrude into or take over what others are doing).

B. Several inattentive or hyperactive-impulsive symptoms were present prior to age 12 years.

C. Several inattentive or hyperactive-impulsive symptoms are

ODD

- ODD is a **persistent pattern of angry/irritable mood**, **argumentative/defiant behavior**, or **vindictiveness** lasting at least **6 months**, observed **during interactions with at least one non-sibling**.

🧒 Core Symptoms: Divided into 3 Clusters (DSM-5)

Cluster	Behaviors
1. Angry/Irritable Mood	Often loses temper, touchy or easily annoyed, angry and resentful
2. Argumentative/Defiant Behavior	Argues with authority figures, refuses to comply, deliberately annoys others, blames others for own mistakes
3. Vindictiveness	Spiteful or vindictive at least **twice in the past 6 months**

Elimination Disorders (Enuresis, Encopresis), Sleepwalking, and Tics

- The term enuresis refers to the habitual involuntary discharge of urine, usually at night, after the age of expected continence (age 5)

🌙 Types of Enuresis (DSM-5)

Type	Description
Nocturnal-only Enuresis	Urination during **nighttime sleep only** (most common)
Diurnal-only Enuresis	Urination during **waking hours** (e.g., school)
Combined type	Both **daytime and nighttime** episodes

- **Encopresis** is the **repeated passage of feces into inappropriate places** (e.g., clothing, floor), **whether involuntary or intentional**, **at least once a month for 3 months**, in a child who is **at least 4 years old** (developmental age).

- The onset of sleepwalking disorder is usually between the ages of 6 and 12. The disorder is classified in parasomnias in DSM-5.
- The symptoms of sleepwalking disorder involve repeated episodes in which a person leaves his or her bed and walks around without being conscious of the experience or remembering it later

- **Tics** are **sudden, rapid, recurrent, nonrhythmic motor movements or vocalizations**.
  Tic Disorders are classified under:
  Neurodevelopmental Disorders

🎯 Types of Tics

Type	Description	Examples
Motor Tics	Involuntary body movements	Eye blinking, shoulder shrugging, facial grimaces
Vocal (Phonic) Tics	Involuntary sounds or utterances	Throat clearing, sniffing, grunting, repeating words (echolalia)

📊 DSM-5 Tic Disorders Classification

Disorder	Duration	Tics Involved	Onset Age
Tourette's Disorder	>1 year	Multiple motor + at least 1 vocal tic	Before age 18
Persistent (Chronic) Motor or Vocal Tic Disorder	>1 year	Only motor **OR** vocal tics	Before age 18
Provisional Tic Disorder	<1 year	Motor and/or vocal tics	Before age 18
Other/Unspecified Tic Disorders	Does not meet full criteria; due to medical/substance/etc.	-	Any

criteria for
Autism Spectrum Disorder

DSM-5

A. Persistent deficits in social communication and social interaction across multiple contexts, as manifested by the following, currently or by history (examples are illustrative, not exhaustive; see text):

1. Deficits in social-emotional reciprocity, ranging, for example, from abnormal social approach and failure of normal back-and-forth conversation; to reduced sharing of interests, emotions, or affect; to failure to initiate or respond to social interactions.
2. Deficits in nonverbal communicative behaviors used for social interaction, ranging, for example, from poorly integrated verbal and nonverbal communication; to abnormalities in eye contact and body language or deficits in understanding and use of gestures; to a total lack of facial expressions and nonverbal communication.
3. Deficits in developing, maintaining, and understanding relationships, ranging, for example, from difficulties adjusting behavior to suit various social contexts; to difficulties in sharing imaginative play or in making friends; to absence of interest in peers.

B. Restricted, repetitive patterns of behavior, interests, or activities, as manifested by at least two of the following, currently or by history (examples are illustrative, not exhaustive; see text):

1. Stereotyped or repetitive motor movements, use of objects, or speech (e.g., simple motor stereotypies, lining up toys or flipping objects, echolalia, idiosyncratic phrases).
2. Insistence on sameness, inflexible adherence to routines, or ritualized patterns of verbal or nonverbal behavior (e.g., extreme distress at small changes, difficulties with transitions, rigid thinking patterns, greeting rituals, need to take same route or eat same food every day).
3. Highly restricted, fixated interests that are abnormal in intensity or focus (e.g., strong attachment to or preoccupation with unusual objects, excessively circumscribed or perseverative interests).
4. Hyper- or hyporeactivity to sensory input or unusual interest in sensory aspects of the environment (e.g., apparent indifference to pain/temperature, adverse response to specific sounds or textures, excessive smelling or touching of objects, visual fascination with lights or movement).

C. Symptoms must be present in the early developmental period (but may not become fully manifest until social demands exceed limited capacities, or may be masked by learned strategies in later life).

D. Symptoms cause clinically significant impairment in social, occupational, or other important areas of current functioning.

E. These disturbances are not better explained by intellectual disability (intellectual developmental disorder) or global developmental delay. Intellectual disability and autism spectrum disorder frequently co-occur; to make comorbid diagnoses of autism spectrum disorder and intellectual disability, social communication should be below that expected for general developmental level.

Note: Individuals with a well-established DSM-IV diagnosis of autistic disorder, Asperger's disorder, or pervasive developmental disorder not otherwise specified should be given the diagnosis of autism spectrum disorder. Individuals who have marked deficits in social communication, but whose symptoms do not otherwise meet criteria for autism spectrum disorder, should be evaluated for social (pragmatic) communication disorder.

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🎓 Quick Mnemonic for ASD Features: "A-U-T-I-S-M"

- Avoids eye contact
- Unusual interest in objects
- Tantrums with change
- Impaired social skills
- Speech delays
- Motor mannerisms

TABLE 15.2
Other Disorders Sometimes Associated with Intellectual Disability

Clinical Type	Symptoms	Causes
No. 18 trisomy syndrome	Peculiar pattern of multiple congenital anomalies, the most common being low-set malformed ears, flexion of fingers, small jaw, and heart defects	Autosomal anomaly of chromosome 18
Tay-Sachs disease	Hypertonicity, listlessness, blindness, progressive spastic paralysis, and convulsions (death by the third year)	Disorder of lipoid metabolism, carried by a single recessive gene
Turner's syndrome	In females only; webbing of neck, increased carrying angle of forearm, and sexual infantilism; intellectual disability may occur but is infrequent	Sex chromosome anomaly (XO)
Klinefelter's syndrome	In males only; features vary from case to case, the only constant finding being the presence of small testes after puberty	Sex chromosome anomaly (XXY)
Niemann-Pick's disease	Onset usually in infancy, with loss of weight, dehydration, and progressive paralysis	Disorder of lipoid metabolism
Bilirubin encephalopathy	Abnormal levels of bilirubin (a toxic substance released by red cell destruction) in the blood; motor incoordination frequent	Often, Rh (ABO) blood group incompatibility between mother and fetus
Rubella, congenital	Visual difficulties most common, with cataracts and retinal problems often occurring together, and with deafness and anomalies in the valves and septa of the heart	The mother's contraction of rubella (German measles) during the first few months of her pregnancy

Source: Based on American Psychiatric Association (2013); Harris (2006).

- **Phenylketonuria (PKU)** is a **rare inherited metabolic disorder** in which the body cannot **break down the amino acid phenylalanine** due to a **deficiency of the enzyme phenylalanine hydroxylase (PAH)**.